MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01571

Reg. Diat. No. 950

1. PLACE OF DEATH:

County: Cecil

City or town: Porters Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Cecilton. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Porters Bridge

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Reuben Benedict

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widower

6.(b) Name of husband or wife: Jennie S. Benedict

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1877

8. AGE:

Years	Months	Days	If less than one day
69	11	8	..... hrs. ..... min.

9. Birthplace: Rock Stump Md. (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business:

FATHER

12. Name: Henry Benedict

13. Birthplace: Lancaster Co Pa.

MOTHER

14. Maiden name: Unknown.

15. Birthplace:

16. Informant: James Benedict

Address: Perryville Md.

17. Chestnut Level. Pa. Date thereof: Feb. 23. 1947

(Burial, cremation, or removal: Which?) (month) (day) (year)

Cemetery or crematory: Chestnut Level. Lane Co. Pa.

Location: Elkmore.

18. Funeral director: F. L. Caulfinger

Address: Peach Bottom Pa

19. Feb 19 1947 L M Worthington

(Date rec'd by registrar) 19 ..... Registrar

Permit issued 2-19-47

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 1947, at 2 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary	
Due to Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other

Address: Rising Sun Md. Date signed 2-18-47

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

01572

Reg. Dist. No. 960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

1. PLACE OF DEATH:

County: CECIL

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 9 mos. 21 days

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland

How long in hospital or institution? 34 yrs. 5 mos. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Garrett

City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: Philippine Insurrection

3.(a) FULL NAME: COMBS, William C.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age: —— years

7. Birth date of deceased (mo., day, yr.): December, 1878 (day unknown)

8. AGE: Years	Months	Days	If less than one day
68	2	?	____ hrs. ____ min.

9. Birthplace: Oakland, Maryland
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Charles A. Combs - Deceased
13. Birthplace: Barton, Maryland

MOTHER
14. Maiden name: Sarah A. Harris - Deceased
15. Birthplace: Mansfield, Ohio

16. Informant: Walter A. Combs - Brother
Address: Oakland, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-18-47 (month) (day) (year)

Cemetery or crematory: Oakland Cemetery

Location: Oakland, Maryland

18. Funeral director: Pennington & Son
Address: Havre de Grace, Maryland

19. Feb. 18 1947 (Date rec'd by registrar) Irene E. Dingle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 19 47 at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 39 to Feb. 18 19 47

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Multiple infarction (brain)	24 hrs.
Due to: Cardiac infarction with mural thrombus	Unknown
Due to: Arteriosclerotic coronary disease	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of: ——

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ——

Means of injury: ——— Injured at work? ——

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 2-18-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

01573

Reg. Dist. No. 960

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville, Md., Rural
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place of death? 53 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Ellerslie, Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clarita Sophie Dalcour Coudon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Coudon of H
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): April 1, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	19	....hrs. ....min.

9. Birthplace: Cuba
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Augustine Dalcour
13. Birthplace: Cuba

MOTHER
14. Maiden name: Clarita de Bullet
15. Birthplace: Cuba

16. Informant: Henry F. Coudon
Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1947 (month) (day) (year)
Cemetery or crematory: Coudon Plot
Location: Ellerslie, Perryville, Md.
18. Funeral director: Wm. A. Patterson & Son
Address: Perryville, Md.
19. Feb. 22, 1947 (Date rec'd by registrar) Irene E. Dougherty (Irene E. Dougherty) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19, 1947, at 1P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 19 1947 and that I last saw h... alive on Feb 19 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Hypertension	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D.
Address: Havre de Grace, Md. Date signed 2/21/47
M. D. or other

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01574

Reg. Diat. No. 96

1. PLACE OF DEATH:
County CECIL
City or town PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.Va. County
City or town Millville
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME
CHARLES S. GRAY

3.(b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18, 1897

8. AGE: Years	Months	Days	If less than one day
49	8	29	..... hrs. ..... min.

9. Birthplace Jefferson Co., W.Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Benjamin F. Gray - deceased
13. Birthplace Jefferson Co., W.Va.

MOTHER
14. Maiden name Sarah Jane Piper - deceased
15. Birthplace Jefferson Co., W.Va.

16. Informant Sister, Mrs. Mabel Ballenger
Address Millville, W.Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb.18,1947 (month) (day) (year)
Cemetery or crematory Unknown
Location Harpers Ferry, W.Va.

18. Funeral director PENNINGTON & SON
Address Havre de Grace, Md.

19. Feb 18 1947 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947 at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1947 to Feb. 17 1947 and that I last saw him alive on February 17 1947

Immediate cause of death	DURATION
Disease of the Coronary arteries:	
(Coronary Thrombosis)	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations --

Date of op. .....

Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of .....
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work?

23. SIGNATURE A. E. Trollinger M. D. or other
Address VAH Perry Point, Md. Date signed 2-18-47
A. E. TROLLINGER, M.D., Clinical Director

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-36

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

01575

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Edward Harvey Gray

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1864

8. AGE: Years	Months	Days	If less than one day
82	3	24	— hrs. — min.

9. Birthplace: Cecil Co. Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Penn. R.R.

FATHER 12. Name: Isaac Gray

FATHER 13. Birthplace: Penn.

MOTHER 14. Maiden name: Mary Carter

MOTHER 15. Birthplace: Md.

16. Informant: Mrs. Mary E. Bennett

Address: R. Stokes St. Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6 1947 (month) (day) (year)

Cemetery or crematory: Methodist Ch. Yd.

Location: Charlestown, Cecil Co. Md.

18. Funeral director: R. Madison Mitchell

Address: Havre de Grace, Md.

19. Feb. 6 1947 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3, 1947, at 6.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3, 1946, to Feb. 3 1947

and that I last saw him alive on Feb 3, 1947

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to: Hypertension	years
Due to: Cardio Vascular disease & Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Leland, M.D. M. D. or other

Address: Port Deposit Date signed 2-5-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01576

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: North East (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Admitted Patient

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Annie Rebeca Groves

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Richard H. Groves

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 24 1852

8. AGE: Years	Months	Days	If less than one day
94	4	3	..... hrs. ..... min.

9. Birthplace: North East Rural, Cecil Co. Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William Counts

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Mary Grace

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Edward Wilson

Address: North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 1947 (month) (day) (year)

Cemetery or crematory: Methodist

Location: St. Georges, Md

18. Funeral director: Joseph A. Graves

Address: North East, Md

19. 3-1-1947 (Date rec'd by registrar) Lydia E. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Feb. 1947, at 10:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Feb. 1947, to 27 Feb 1947 and that I last saw h.e.r. alive on 23 Feb. 1947

Immediate cause of death	DURATION
Arteriosclerosis, cerebral	1 year
Due to: Arteriosclerosis, generalized	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Klaus H Thuebner M.D. (M. D. or other)

Address: North East, Md Date signed: 27 Feb 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01577

Reg. Dist. No. 92

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Bethel St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Henry Hammond.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	married

6.(b) Name of husband or wife: no information

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): mch 15 1876

8. AGE:

Years	Months	Days	If less than one day
70	11	4	hrs. min.

9. Birthplace: Elkton Cecil md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Stephen Hammond
13. Birthplace: Elkton Md

MOTHER
14. Maiden name: no information
15. Birthplace: no information

16. Informant: Eddie Harris
Address: Elkton Md

17. Burial — Date thereof: Feby 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Elkton Colored Cemetery

Location: Elkton, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Maryland

19. Feb 18 1947 — F R Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1947 at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R L Dodson MD
M. D. or other

Address: Rising Sun Md Date signed: 2/15-47

Medical Examiner
Cecil County

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 01578 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary M Magraw Hansen

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Comm. U.S. Hansen
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 17 1870
8. AGE: Years: 76 Months: 10 Days: 27 If less than one day: ..... hrs. ..... min.
9. Birthplace: Fort Thomas Rem Harford Co Md (Town, county and state)
10. Usual occupation: H. W.
11. Industry or business: Home
FATHER
12. Name: Dr. James M. Magraw
13. Birthplace: Harp-de-Grace Md
MOTHER
14. Maiden name: Katherine W. Stumph
15. Birthplace: Perryville Md
16. Informant: J. F. Magraw
Address: Perryville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 18, 1947 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Feb. 18 1947 Irene E. Daugherty
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1947 at 8:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1942 to Feb 14 1947
and that I last saw h alive on Feb 14 1947

	DURATION
Immediate cause of death: Cerebral Apoplexy	3 mins
Due to: Hypertension	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md. Date signed: 2/17/47

1-36

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-0)

CERTIFICATE OF DEATH

0157?

Reg. Diat. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Chesapeake Cit

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Reuben Hevlow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Widowed.

6.(b) Name of husband or wife: Annie S. Hevlow

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct. 17, 1858

8. AGE: Years	Months	Days	If less than one day
89	3	16	..... hrs. ..... min.

9. Birthplace: Fredricktown Md (Town, county, and state)

10. Usual occupation: Retd Farmer

11. Industry or business:

FATHER — 12. Name: James Hevlow

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ellen Briley

15. Birthplace: Maryland

16. Informant: Jos. Hevlow

Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4, 1947 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Near Chesapeake City Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. February 4th 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1947, at 12:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to Feb 1, 1947

and that I last saw h... alive on Feb 2 1947

Immediate cause of death: Senile Degeneration — DURATION: 2 weeks

Due to: Old Age

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos J Davis MD M. D. or other

Address: Chesapeake Md Date signed: 2/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

01580

CERTIFICATE OF DEATH

Reg. Dist. No. 960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: Perry Point, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month and 14 days

Hospital, institution, or street address where death occurred: VAH, Perry Point, Maryland

How long in hospital or institution? Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 9515 East Stanhope Road, Rock Creek Hill (If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: SUMNER NORTHUP HUME

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: —

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): March 15, 1898

8. AGE: Years	Months	Days	If less than one day
48	11	8	hrs. min.

9. Birthplace: Chicago, Ill. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Sumner Hume - Deceased

FATHER — 13. Birthplace: Chicago, Ill.

MOTHER — 14. Maiden name: Mildred Northup - Deceased

MOTHER — 15. Birthplace: Brooklyn, N.Y.

16. Informant: Mrs. Stanley Suydam - sister

Address: 9515 E. Stanhope Rd., Kensington, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/26/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Myer, Virginia

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Feb. 26 1947 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1947, at 5:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 9 1947, to Feb. 23 1947 and that I last saw him alive on February 23 1947

	DURATION
Immediate cause of death: Cerebral Embolism	24-36 hr
Due to: Coronary Artery disease with myocardial infarction	45 days
Due to: Arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, M.D., Clinical Director

Address: VAH, Perry Point, Md. Date signed: 2-25-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 01584 60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bainbridge, Md.

How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Armstrong

City or town: A pollo

(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 N. 3rd street

(If rural, give LOCATION)

2.(a) If veteran, name war: - - -

3.(a) FULL NAME: John Sirwell Knepshield

3.(b) Social Security Number: 210-20-1360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White/US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 17, 1929

8. AGE: Years	Months	Days	If less than one day
17	4	11	..... hrs. ..... min.

9. Birthplace: Apollo (Town) Armstrong (County) Pennsylvania (State)

10. Usual occupation: Student

11. Industry or business: - - -

FATHER — 12. Name: Marland Sirwell Knepshield

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: \ \ \

MOTHER — 15. Birthplace:

16. Informant: U.S. Naval Service Record

Address: Bainbridge, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 1, 1947 (month) (day) (year)

Cemetery or crematory: To, Apollo, Pa.

Location:

18. Funeral director: Lee A. Patterson & Son

Address: Aiken, Maryland, Perryville, Md.

19. Mar 1 (Date rec'd by registrar) 19 47 Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 February 19 47, at 0340 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Feb. 19 47, to 28 Feb. 19 47 and that I last saw him alive on 28 Feb. 19 47

Immediate cause of death	DURATION
Shock	
Due to Hemorrhage, massive, left thorax and pericardium.	?
Due to Wound, puncture, left chest, into the right ventricle of the heart.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of 2/28-47

Where did injury occur? Bainbridge (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where)? Bainbridge Camp

Means of injury: Pocket Knife Injured at work?

23. SIGNATURE: R L E Dodson MD M. D. or other

Address: Rising Sun Md. Date signed 3-1-47

Medical Examiner Cecil County

1-35.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01582 (46)

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15—1 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Months.

Hospital, institution, or street address where death occurred:
U.S.N. Hospital Bainbridge, Md.

How long in hospital or institution? 31 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infanta give residence of mother)

State: Maryland County: Cecil

City or town: Bainbridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bldg. 911 apt 14
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Peggy Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	✓

6.(b) Name of husband or wife: 2 June 1946

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 3, 1946

8. AGE: Years: | Months: 8 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bainbridge Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Thomas Lee

FATHER — 13. Birthplace: Glenwood, Minnesota

MOTHER — 14. Maiden name: Marilyn Yvonne Johnson

MOTHER — 15. Birthplace: Escanaba, Michigan

16. Informant: Thomas Edward Lee

Address: Village 911-14 - Bainbridge Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Feb. 13 1947 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Feb. 12 1947 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 February 1947, at 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Feb 1947, to 11 Feb 1947

and that I last saw h[illegible] alive on 11 Feb 1947

Immediate cause of death	DURATION
Bronchial pneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Death due to Bronchial pneumonia Bilateral

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Graham R. Johnston M. D. or other
O.P.D., U.S.N.H.-C.

Address: Bainbridge, Md. Date signed: 11 Feb 47

2-33-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01583

Reg. Diat. No. 42

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Union Hospital Elkton Md

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Conowingo
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wilfred Lewis Tove

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1946

8. AGE: Years | Months 5 | Days 26 | If less than one day hrs. min.

9. Birthplace Elkton, Cecil Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name W. B. Tove

13. Birthplace Beachbottom Pa

14. Maiden name Clara E. Crothers

15. Birthplace Rising Sun

16. Informant W. B Tove

Address Conowingo, Md

17. Burial Date thereof Feb. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Darlington Cemetary

Location Darlington, Md.

18. Funeral director Ralph M Reed

Address Rising Sun, Md.

19. Feb 3 1947 F R Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1947 at 1 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31. 1947 to Feb 3 1947 and that I last saw him alive on Feb 2 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. McLaughlin M. D. or other

Address Elkton Md Date signed 2/3/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 0158496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Otsego St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elmore H. Owens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Eleanor C. Owens
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 24, 1879

8. AGE: Years	Months	Days	If less than one day
67	2	30	hrs. min.

9. Birthplace: Perryville, Cecil Co., Md.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: General Store

FATHER
12. Name: Elmore H. Owens
13. Birthplace: Perryville, Md.

MOTHER
14. Maiden name: Margaret Jane Wilson
15. Birthplace: Perryville, Md

16. Informant: Margaret Owens Bailey
Address: Otsego St., Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25, 1947 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port De posit, Md. Rural

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Feb. 26 1947 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 1947, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to Feb 23 1947
and that I last saw him alive on Feb 22 1947

Immediate cause of death	DURATION
Metastatic Carcinoma of Small Intestines	1 yr
Due to Carcinoma of Prostate	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md. Date signed 2/24/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01585

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City RD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 y
Hospital, institution, or street address where death occurred:
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City RD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George E Reddear

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widowed

6.(b) Name of husband or wife: Mollie Reddear
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 3 1856

8. AGE: Years: 90 | Months: 9 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Chesapeake City Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Henry Reddear
13. Birthplace: Chesapeake City Md

MOTHER
14. Maiden name: Janima Mercer
15. Birthplace: Chesapeake City Md

16. Informant: Cecil Reddear
Address: Chesapeake City Md RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 8 1947 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: Chesapeake City Md RD

18. Funeral director: H W Pierce
Address: Elkton Md

19. February 8th 1947 (Date rec'd by registrar) Ina Ratcliffe Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute Coronary Thrombosis — DURATION

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R L Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed: 2-5-47

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

01586

Reg. Dist. No. 920

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
216 West Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob F. Steele

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Gertrude Steele
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 21 1865

8. AGE: Years: 81 | Months: 4 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jeansville Pa
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Garrett F Steele
13. Birthplace: Pa

MOTHER
14. Maiden name: Sarah Mell
15. Birthplace: no information

16. Informant: Garrett Steele
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 16 1947 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery near Fair Hill Md
Location:

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Feb 15 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1947 at 8 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to Feb. 13 1947 and that I last saw him alive on Feb. 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	Feb. 11, 1947
Due to Arteriosclerosis and hypertension	
Due to	
Other conditions Dr. J	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Milford W. Spreadbury, M.D.
M. D. or other
Address: Elkton, Md. Date signed: Feb. 13, 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

235

STATE OF MARYLAND—CERTIFICATE OF DEATH

01587

1. PLACE OF DEATH

County Cecil (94a) Registration Dist. No. 900

Village or City Warwick No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary A. Sullivan If U. S. Veteran, specify WAR

(a) Residence: No. Warwick rd. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) June 6th 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. housekeeping.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own home

10. Date deceased last worked at this occupation (month and year) 1947

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Thomas Sullivan

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Katherine Devine

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Bradford Sullivan (Address) Middletown Rd.

18. BURIAL, CREMATION, OR REMOVAL Place Bohemia Cemetery Date 2-17-1947

19. UNDERTAKER (Address) Townsend Walls

20. FILED Feb 16, 1947 Mrs Harold W. Cheyney Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February 13th 1947 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Jan 1st 1947 to Feb. 13 1947

last saw her alive on Feb. 12 1947; death is said to have occurred on the date stated above, at 9 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	1 day

Other **Contributory Causes** of importance:

Arteriosclerosis	unknown

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any wey related to occupation of deceased?

If so, specify

(Signed) J D Weles M. D.

(Address) Middletown Delaware

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98)

CERTIFICATE OF DEATH

Reg. Diat. No. 01588 (20)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 years
Hospital, Institution, or street address where death occurred: W. Main St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Fannie VanderGrift

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife: Frank Vandegrift
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 28, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	11	..... hrs. ..... min.

9. Birthplace: Elkton Md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER 12. Name: Marks Lehrman
13. Birthplace: Elkton, Md
MOTHER 14. Maiden name: No Information
15. Birthplace
16. Informant: Frank Vandegrift
Address: Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12, 1947 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md
18. Funeral director: H.W. Lippert
Address: Elkton, Md
19. Feb 11 1947 (Date rec'd by registrar) F.R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1947, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1947, to Feb. 9 1947
and that I last saw h.. alive on Feb. 5 1947

	DURATION
Immediate cause of death: Toxemia	1 week
Due to: Gangrene of Rt. Leg.	5 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other
Address: Elkton, Md Date signed: 2/11/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

01589

Reg. Dist. No. 960

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 9 mos. 25 days

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American War

3. (a) FULL NAME: MICHAEL WILLINGER

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 9, 1882

8. AGE:

Years	Months	Days	If less than one day
65	0	17	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: No record available
13. Birthplace:

MOTHER
14. Maiden name: No record available
15. Birthplace:

16. Informant: —
Address: —

17. Removal Date thereof: Feb. 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON
Havre de Grace, Maryland

19. Feb. 27 1947 Irene E. Douglass
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1947, at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1945, to February 26 1947
and that I last saw him alive on February 26 1947

	DURATION
Immediate cause of death: Hemorrhage, cerebral	1 day
Due to: Arteriosclerosis, generalized and cerebral	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, M.D., Clin. Director
Address: VAH, Perry Point, Md. Date signed: 2-27-47

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